HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Glucocorticoids - Oral

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The member meets ALL of the following:

☐ Is prescribed the Glucocorticoid, Oral for a diagnosis that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication

☐ Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Q2. The member has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Glucocorticoids, Oral approved or medically accepted for the beneficiary's diagnosis. Describe all applicable medical reasons the beneficiary cannot use the preferred medication(s) in the same class. Submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, lab results, etc.) supporting this non-preferred request. Include drug name, dose, and start/stop dates.

☐ Yes ☐ No

Q3. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to inhaled fluticasone propionate.

☐ Yes ☐ No

Q4. For a diagnosis of primary immunoglobulin A nephropathy (IgAN), all of the following:

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Glucocorticoids - Oral

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:

- ☐ Has a diagnosis of primary IgAN that is confirmed by a kidney biopsy
- ☐ Is prescribed the requested drug by or in consultation with a nephrologist
- ☐ Is at very high risk for progressive disease or already has progressive disease despite at least three to six months of maximally tolerated doses of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker based on current consensus guidelines
- ☐ Has an estimated glomerular filtration rate greater than or equal to 35 mL/min/1.73 m2

Q5. Additional Information:

_____ _____

Prescriber Signature Date

v2026